RAYNHAM-TAUNTON PEDIATRICS PATIENT REGISTRATION FORM

PATIENT LAST NAME, FIRST NAME:		
BIRTH DATE: / /		SEX(CIRCLE): MALE FEMALE
RACE(CIRCLE): BLACK/ AMERICAN INDIAN/ HISPANIC/ INDIAN/ MIDDLE EASTERN / NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER/ WHITE/ DECLINE TO SPECIFY		ETHNICITY(CIRCLE): NOT HISPANIC OR LATINO HISPANIC OR LATINO
STREET ADDRESS OR P.O. BOX:		
CITY/TOWN, STATE, ZIP CODE		
PRIMARY E-MAIL ADDRESS:		
HOME PH: ( )- -	WORK PH: ( )- -	CELL PH: ( )- -
PRIMARY INSURANCE INFORMATION: (IF NEWBORN PLEASE NOTIFY INSURANCE)		
INSURANCE NAME:		
POLICY NO:	GROUP NO:	
SUBSCRIBER NAME:	SUBSCRIBER DOB:	
SECONDARY INSURANCE INFORMATION:		
INSURANCE NAME:		
POLICY NO:	GROUP NO:	
SUBSCRIBER NAME:	SUBSCRIBER DOB:	
MOTHER INFORMATION: NAME:_____ ADDRESS:_____ CITY/ST/ZIP:_____ PH:_____	FATHER INFORMATION: NAME:_____ ADDRESS:_____ CITY/ST/ZIP:_____ PH:_____	
PLEASE LIST ANYONE WHO HAS YOUR PERMISSION TO BRING YOUR CHILD TO OUR OFFICE FOR MEDICAL CARE IN YOUR ABSENCE AND/OR WHO IS AUTHORIZED TO RECEIVE YOUR CHILD'S MEDICAL INFORMATION. IN THE EVENT OF AN EMERGENCY, ONLY PEOPLE YOU AUTHORIZE IN WRITING, PER HIPAA REQUIREMENTS, WILL BE ABLE TO ACCOMPANY YOUR CHILD FOR TREATMENT WITHOUT YOU BEING PRESENT.		
NAME AND DOB:		
PREFERRED PHARMACY: NAME:_____ ADDRESS:_____		
REGULAR PHYSICIAN IF NOT A PATIENT OF THIS PRACTICE:		
MEDICATIONS:		
DRUG ALLERGIES:		

AUTHORIZATION TO PAY: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF RAYNHAM-TAUNTON PEDIATRICS FOR SURGICAL OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

SIGN (PATIENT OR GUARDIAN) _____